

FILED DEC 27 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42230

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10468

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2077	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5103a Lillian Ave.,		e. STREET ADDRESS (If rural, give location) 5103 Lillian Ave., 0	
3. NAME OF DECEASED (Type or Print) a. (First) Alexander b. (Middle) W Feigel c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) Dec 7th, 1950	
5. SEX male 0	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Jan 13th, 1875 75
9. AGE (In years, last birthday) 75	10. UNDER 1 YEAR Months Days	11. UNDER 10 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY City	
11. BIRTHPLACE (State or foreign country) St. Louis 0		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME William Feigel		13b. MOTHER'S MAIDEN NAME Nancy Hobbs	
14. NAME OF HUSBAND OR WIFE Anna Feigel			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT'S SIGNATURE OR NAME Anna Feigel, 5103a Lillian Ave.,		ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Bronchial Asthma DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	
21f. HOW DID INJURY OCCUR? 241X			
22. I hereby certify that I attended the deceased from Jan. 24, 1950, to Dec. 6, 1950, that I last saw the deceased alive on Dec. 6th, 1950, and that death occurred at 4 a.m., from the causes and on the date stated above.			
23a. SIGNATURE SOLON CAMERON (Degree or title)		23b. ADDRESS 508 N. Grand, St. Louis 3, Mo	
23c. DATE SIGNED 12/8/50.			
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 12/11/50	
24c. NAME OF CEMETERY OR CREMATORY Friedens Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. DEC 8 1950		REGISTRAR'S SIGNATURE J. B. Lasater	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Diedrich F. Home, 8319 Hallsferry			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Me

working under my personal supervision.

Student Embalmer No.....

Signed.....

E. C. Remelius

Signed.....
Student Embalmer

Licensed Embalmer No. 4283

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.